Report of Suspected Alcohol/Drug Impairment Form

In conjunction with DDSN's Drug-Free Workplace & Alcohol and Drug Testing for Employees Policy, this form is to be used whenever a covered worker (as defined by this policy) is suspected of being under the influence of alcohol or drugs, and objective observations support a "Reasonable Suspicion" screening test. The form should be completed as soon as possible when suspected policy violations are observed, and submitted to Human Resources for follow-up and confidential retention.

Name of Covered Worker Suspected of Alcohol/Drug Use: _____

Position or Job Function of this Covered Worker:_____

Regional Center, Facility, or Work Site: _____

Address: _____ City: _____ Zip: _____

Describe the activity, behavior or incident observed that prompted this report.

Date(s) Observed: _____

Time(s) Observed: _____

Where Did this Happen? _____

What objective evidence gives Reasonable Suspicion that a covered worker was under the influence of alcohol or drugs at the time of the observation or incident.

_____

_____

_____

_____

Did you observe the covered worker do any of the following at a DDSN worksite, or while conducting business for DDSN?

☐ Yes ☐ No

☐ Has Alcohol in Possession ☐ Has Drugs in Possession ☐ Has Drug Paraphernalia in Possession
☐ Has or Consumed Alcohol in Personal Vehicle ☐ Has or Consumed Alcohol in State Vehicle
☐ Has or Used Drugs in Personal Vehicle ☐ Has or Used Drugs in State Vehicle
☐ Has Drug Paraphernalia in State Vehicle ☐ Provided Alcohol or Drugs to Others
☐ Provided Drug Paraphernalia to Others ☐ Used Alcohol or Drugs Prior to Reporting to Work

Is your report of Reasonable Suspicion based upon the physical appearance or behaviors of the covered worker, not one particular incident? ☐ Yes ☐ No

- *If "Yes," have you notified your (or the covered worker's) supervisor?* ☐ Yes ☐ No
- *If "Yes," please check the descriptions below that best indicate your observation.*

Walking/Standing ☐ Normal

☐ Stumbling ☐ Swaying ☐ Staggering ☐ Falling Down ☐ Unsteady
☐ Holding on to Items to Keep from Falling ☐ Unable to Stand ☐ Unable to Walk

Speech ☐ Normal

☐ Shouting ☐ Slow ☐ Slurred ☐ Constant Talking ☐ Stammering
☐ Whispering ☐ Rambling ☐ Mumbling ☐ Incoherent ☐ Drooling
☐ Used Profanity ☐ Talks Nonsense

Physical Appearance & Activity ☐Normal

☐Flushed Face	☐Facial Itching	☐Pale/Ashen Skin Complexion	☐Unusual Cuts, Bruises or Rashes
☐Sweaty Face	☐ Bloodshot Eyes	☐Dilated (Large) Pupils in Eyes	☐Pinpoint (Tiny) Pupils in Eyes
☐Eyelid Tremors	☐Glassy Eyes	☐Light-Sensitive Eyes	☐Shaky/Trembles/Shivers
☐Blank Stares	☐Watery Eyes	☐Faint Alcohol Odor on Breath	☐Strong Alcohol Odor on Breath
☐Droopy Eyes	☐Very Red Eyelids	☐No Alcohol Odor on Breath	☐Smells of Marijuana or Other Drugs
☐Bloody Nose	☐Vomiting/Nausea	☐Dry Mouth/White Lips	☐Impaired Driving Ability
☐Stained Clothing		☐Messy/Untidy Appearance	☐Very Bad Body Odor

Behavior ☐Normal

☐Sleepy	☐Suspicious of Others	☐Overly Worried	☐Crying	☐Frustrated/No Tolerance of Others
☐Irritable	☐Sad/Withdrawn	☐Argumentative	☐Silent	☐Avoids Interaction with Others
☐Confused	☐Over Reaction	☐Seems Disoriented	☐Acts Panicky	☐Unusual Giggling or Laughter
	☐Exhausted/ Weary	☐Excited/ "Hyper"	☐Unusually "Silly"	☐Threatening/Violent Outbursts
☐Mood Changes Significantly after Lunch or Break			☐Shortened Attention Span	

Witness's Signature& Date

Name & Title of Person Recording Information, if Witness Prefers to Remain Anonymous

Note: If this Reasonable Suspicion of Drug and/or Alcohol Use is based upon the physical appearance or behaviors displayed by the covered worker, the supervisor, AOD, facility administrator or HR staff member should observe the worker him/herself. In such cases, a second witness should confirm the suspicions to warrant sending the covered worker to be tested for alcohol or drug use.

Recommend Screening for Alcohol/Drug Use (or not)

Supervisor of Covered Worker:_____ Date: _____ Recommended: ☐Yes ☐No

Facility Administrator: _____Date: _____ Recommended: ☐Yes ☐No

Associate State Director: _____ Date: _____ Recommended: ☐Yes ☐No

District HR Director: _____Date: _____ Recommended: ☐Yes ☐No

To Be Completed by the HR Director or Designee

Did Management Agree to Send Covered Worker to be tested for Drug/Alcohol Use? ☐Yes ☐No

If "Yes," Date & Time Scheduled for Testing: _____

Does Covered Worker Perform Safety-Sensitive Job Duties? ☐Yes ☐No

Did the Covered Worker Agree to be tested? ☐Yes ☐No